



## Atypical Antipsychotic Prior Authorization Form Fee-for-Service Medicaid/PeachCare for Kids PHONE #: 866-525-5827

FAX #: 888-491-9742

**Note:** If the following information is NOT filled in completely, correctly, or legibly the PA process **may** be delayed. **Please complete one form per member.** 

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	Drug	Reason inappropriate choice for member
	Risperidone	
	Seroquel IR	
	Geodon	
		therapy for major depressive disorder only): Reason antidepressant mber: (Complete for each drug/class in the following table)  Reason antidepressant monotherapy is inadequate
	Cymbalta (duloxetine)	
	Effexor (venlafaxine)	
	SSRIs (citalopram [Celexa], escitalopram [Lexapro], fluoxetine [Prozac], fluvoxamine [Luvox], paroxetine [Paxil], or sertraline [Zoloft])	
Conta	risperidone, or Risperdal Consta (if Invegis being requested) or does the member to receive a trial of the appropriate oral a or is the member unable to swallow or us     Yes	or Zyprexa Relprevv is being requested. oral Invega (if Risperdal Consta is being requested), oral Invega, oral ga Sustenna is being requested), or oral Zyprexa (if Zyprexa Relprevv have a history of noncompliance with oral medications and is unable typical antipsychotic before starting long-acting therapy with injection se orally disintegrating tablets?  No or has a psychiatrist been consulted?  d? th center) for administration in a physician's office or outpatient clinic other User portion of the Georgia Health Partnership website at a PA from Physician Services.  Phone:  Phone:
	Health Solutions, Inc. will provide a respo	
in erro		Information intended for the parties identified below. If you have received this transmission lamessage to P.O. Box 3214; Lisle, IL 60532-8214. Distribution, reproduction or any other strictly prohibited.

Reason preferred agents are not appropriate for this member: (Complete for each drug in the following table)

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